Consumers for AFFORDABLE Health Care COALITION

Advocating the right to health care for every man, woman and child.

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By U.S Mail and Electronically

March 22, 2006

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECONDASSESSMENT YEAR (2007)

Dear Dr. McAfee and Ms. Therberge:

Please find enclosed for filing in the above captioned matter, the following documents from Consumers for Affordable Health Care. Please contact me with any questions.

1. Filing Cover Sheet

2. Pre-filed Testimony of Dr. Kenneth Thorpe

Thank you for your attention in this matter.

Respectfully submitted,

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Pc: Service List (by US Mail and electronically)

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	**FILING COVER SHEET**
DETERMINED BY DIRIGO HEALTH	)	
FOR THE SECONDASSESSMENT YEAR	)	
(2007)	)	

Date filed: March 22, 2006

Name of party: Consumers for Affordable Health Care

Document title: Pre-filed Testimony of Dr. Kenneth Thorpe

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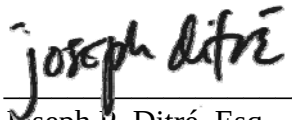

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STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	**PRE-FILED TESTIMONY**
REVIEW OF AGGREGATE	)	**OF DR. KENNETH THORPE**
MEASURABLE COST SAVINGS	)	**SUBMITTED BY**
DETERMINED BY	)	**CONSUMERS FOR AFFORDABLE**
DIRIGO HEALTH	)	**HEALTH CARE**
FOR THE SECOND ASSESSMENT YEAR	)	
(2007)	)	

DR. KENNETH THORPE

Professional Background:

Q. Please state your name and address.

A. Dr. Kenneth Thorpe, Department of Health Policy & Management Rollins School of Public Health, Emory University, 1518 Clifton Road, NE, Atlanta, Georgia, 30322

Q. What is your position at Emory University?

A. I am the Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management at the Robbins School of Public Health. I have held that position since 1999.

Q. What is your education?

A. I received by my B.A. in Political Science from the University of Michigan in 1978. I received my M.A. in Public Policy from Duke University in 1980, and my Ph.D. from Rand Graduate Institute in Public Policy in 1985.

Q. Could you tell us about some of your prior faculty appointments?

A. I served as the Vanselow Professor, Health Systems Management, Tulane University School of Public Health and Tropical Medicine, from 1995 through 1999. I was the Director for the Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine, from 1994-1995. I was Professor of Health Policy and Administration at the University of North Carolina School of Public Health from 1990-1994; an Associate Professor of Health Policy and Management at the Harvard University School of Public Health, from 1989- 1990. I was Director, Program on Health Policy and Health

Care Financing Management and Insurance at Harvard University School of Public Health, from 1988-1990; Assistant Professor, Health Policy and Management, Harvard University School of Public Health, from 1986-1989; and Assistant Professor of Health Administration, Columbia University School of Public Health, from 1983 -1986.

Q. Have you held Visiting Faculty positions?

A. Yes, at Pepperdine University, Columbia and Duke University.

Q. Have you held any position in government?

A. Yes, I was Deputy Assistant Secretary for Health Policy, United States Department of Health and Human Services and Chair of the Quantitative Impacts of Health Care Reform, President Clinton's Health Care Reform Task Force from1993-1995.

Q. What were your duties as Deputy Assistant Secretary?

A. I coordinated all financial estimates and program impact for President Clinton's health care proposals.

Q. What were your duties as Chair of Quantitative Impacts?

A. I directed his administration's estimation efforts in dealing with Congressional health care proposals during the 103rd and 104th Sessions of Congress.

Q. Have you ever testified before Congressional Committees?

A. Yes, as an academic, I testified before several Committees in the U.S. Senate and the House of Representatives.

Q. What are some of your other work experiences?

A. I serve on the Board of Directors for Health Service Research and in 2004 I was a gubernatorial appointee to the Louisiana Governor's Panel on Health Reform.

Q. Have you received any awards?

A. In 1991 I was awarded the Young Investigative Award for the most promising health services researcher in the country under age 40 by the Association for Health Services Research. I also received the Hettlemon Award for academic and scholarly research at the University of North Carolina, and I received an "Up and Comers" award by Modern Healthcare.

Q. Have you published?

A. I have authored and co-authored over 60 articles and, book chapters. I am also a reviewer of several health care journals. I am also on the Editorial Board of Health Affairs.

Q. Are you a presenter?

A. I am a frequent presenter of issues on health care financing and, insurance reform at health care conferences, on television and in the media.

Q. What are your major research and teaching interests?

A. National and State Health Care Policy, Health Care Financing and Organization, and Application of Ecometric Techniques to Health Policy Issues Covering the Uninsured.

Q. I show you what I have marked as *Exhibit A.* Is this a copy of your curriculum vitae?

A. Yes.

Preparation for Testimony

Q. Dr. Thorpe, what did you do to prepare yourself for the testimony you are giving on the issue of review of aggregate measurable costs savings determined by Dirigo Health for the Second Assessment Year?

A. I understand that the Dirigo Health Agency requested a continuance until August 15, 2006 in order to enable it to have the time to obtain the relevant Medicare Cost Reports and data filed with the Maine Health Data Organization using the standardized financial reporting agreed to by the Maine Hospital Association and the Governor's Office of Health Policy and Finance. Since complete and relevant data is not yet available for this the second assessment year, I have reviewed the Dirigo Health Initiatives and Dirigo Board's filing of September 19, 2005, and I have reviewed responses to information requests by the Maine Superintendent of Insurance and Intervenors in the first proceeding. I participated in one conference call with Mercer Government Human Services Consulting and I have talked with Joseph Ditré, Executive Director of and legal counsel to Consumers for Affordable Health Care.

Opinions of the "Sentinel Effect"

Q. Is there is a phenomenon known as the "sentinel effect" in health care reform?

A. Yes, it is a well- known phenomenon. Based on my research and experience with health care reform initiatives, it is reasonable to expect the behavior of health care

providers to be broadly impacted when major new health care initiatives are announced, resulting in lower costs.

Q. What has been your experience with this phenomenon?

A. I have seen this in several respects. First, during the discussion over the Clinton health care plan during 1993 - 1994 there was widespread concern among providers that, if the proposal passed, it would lead to price controls. In the years prior to the debate, private health insurance premiums increased in the double digits –10% - 14%. Growth in premiums fell dramatically through 1996 (0.8% increase in that year) despite the fact that no major changes in federal policy had occurred. The policy debate led employers to move workers into managed care plans at an accelerated rate leading to some of the reduction. Second, the introduction of the State Children's Health Insurance Program ("SCHIP") resulted in an increase in Medicaid enrollment among uninsured children not yet enrolled. The widespread attention to the SCHIP program raised the visibility of the availability and children's eligibility for coverage resulting in an increase in enrollment. In Maine alone, an additional 4,000 uninsured children were enrolled into its Medicaid program during 2004, a much faster rise in enrollment among eligible uninsured children compared to the period prior to Dirigo.

Q. Would you expect this phenomenon to be present from the introduction, implementation, and expansion of the Dirigo Health Initiatives.

A. Yes. For the same reason we have seen rising enrollment nationally when a new state program is initiated. It raises the visibility of existing government programs through new outreach efforts, which result in rising enrollment.

Q. What relevance does it have to the Dirigo Health Agency Board whose responsibility is to calculate the aggregate measurable cost savings?

A. In the previous proceeding before the Superintendent, the Board's determinations of cost savings from the Dirigo Initiatives were challenged by the Lewin Group and others as not reflecting actual savings in the marketplace. Based on my research and experience and the historical aggregate level of health care costs in the State of Maine, I would expect that the "sentinel effect" would result in an increase in the number of uninsured seeking to enroll in Dirigo, resulting in an increase in children enrolling in Maine's Medicaid program. This additional enrollment would likely not have occurred in the absence of the Dirigo program. Higher rates of health insurance coverage translate into less uncompensated care. A reduction in uncompensated care would, other things being constant, result in lower charges, and lower private health insurance payments to providers. This provides an opportunity for health plans to negotiate lower payments resulting in lower growth in premiums.

Opinions on the Cost per Case Mix Adjusted Discharge ("CMAD")

Q. As of March 22, 2006, have you reviewed any documents related to CMAD in the second assessment year?

A. No. I understand that the agency is waiting for the Medicare Cost Reports and other standardized financial reports from the Maine Hospital Association and its members. Once the data is available, I will review the methodology, calculation and analysis provided by the Agency and determine its reasonableness.

Opinions on the Savings From Reductions in Bad Debt and Charity Care ("BD/CC").

Q. Dr. Thorpe, have you begun to review any documents related to BDCC for the second assessment year?

A. Yes, but the data are not complete. Again, I understand that the Agency is waiting for the Medicare Cost Reports to be available in order to have complete data on all of the Maine Hospitals.

Q. Are you familiar with calculations and methodologies for calculating BDCC?

A. Yes, I have developed my own statistical model that estimates the dollar volume of uncompensated care traced to the uninsured by state.

Q. How was the model developed?

A. The model is described in the Appendix prepared by me to the report, Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured*, June 2005, attached hereto as *Exhibit B* beginning at page 23.

Q. Based on this model, did you calculate savings for the reduction of bad debt and charity care for the first assessment year for the previously uninsured attributable to the Dirigo Initiatives?

A. Yes. For 2005 I estimated that there was $132.9 million worth of uncompensated care provided to the uninsured in Maine. Then I adjusted for the growth of health care costs to estimate that there was approximately $125 million worth of uncompensated care in Maine in 2004. This sum is obviously a subset of all uncompensated care because a substantial volume of uncompensated care can be traced to insured patients who do not pay a portion of their bill (e.g., deductibles, co-payments, etc.). The then most recent data from the Current Population Survey (http://pubdb3.census.gov/macro/032005/health/h06_000.htm) showed that the State of Maine had approximately 130,000 uninsured people, resulting in a per member per year cost of $1,025, or about $85 per member per month ("PMPM") for 2005, which I adjusted to $78 PMPM for 2004. I multiplied $78 by 16,293, the number of member months for the previously uninsured who

enrolled in Dirigo, according to the Mercer Report, Tab 11 of the Dirigo Board filing at page 20, ¶D for a total savings in 2004 from previously uninsured bad debt/charity care of $1.3 million, compared to $1.6 million found by Mercer.

Q. Did you apply your model to the cost savings from the underinsured in the first assessment year?

A. Yes. The calculation is the same. I took the $78 PMPM and multiplied against 14,442, the number of member months for previously underinsured enrolled enrollees in Dirigo as stated in the Mercer Report, page 20, ¶E, for total savings of $1.1 million, the same as Mercer concluded.

Q. What about savings from the woodwork effect in the first assessment year?

A. Yes, the calculation is similar. I used the same $78 PMPM and multiplied it against 4,000, or 48,000 member months, which is my estimate of the number of enrollees and member months in MaineCare and SCHIP caused by Dirigo and based on the 6,171 enrollees in Dirigo as found by Mercer at page 20, ¶D (74,060 divided by 12.) A one-to-one ratio of enrollees in Dirigo to woodwork effect in Medicaid and SCHIP is reasonable. I provided the State of Wisconsin Report to support my testimony. I was more conservative. Then I multiplied by 12 to annualize the savings, which calculates to $3.7 million in savings from woodwork effect, compared to $3.0 million as found by Mercer.

Q. Will you be providing supplemental testimony once the documents to which you referred are available?

A. Yes.

Q. Thank you Dr. Thorpe, that is all I have.

KENNETH EARL THORPE

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EDUCATION

1978	Political Science	B.A.	University of Michigan
1980	Public Policy	M.A.	Duke University
1985	Public Policy	Ph.D.	Rand Graduate Institute

FACULTY

1999-Present	Robert W. Woodruff Professor and Chair, Department of Health Policy and Management, Rollins School of Public Health, Emory University
1995-1999	Vanselow Professor, Health Systems Management, Tulane University School of Public Health and Tropical Medicine
1995-1999	Director, Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine
1994-1995	Professor, Health Policy and Administration, University of North Carolina School of Public Health
1990-1994	Associate Professor Health Policy and Administration, University of North Carolina School of Public Health
1989-1990	Associate Professor, Health Policy and Management, Harvard University School of Public Health
1988-1990	Director, Program on Health Policy and Health Care Financing Management and Insurance, Harvard University School of Public Health

1986-1989	Assistant Professor, Health Policy and Management, Harvard University School of Public Health
1983-1986	Assistant Professor, Health Administration, Columbia University School of Public Health

WORK EXPERIENCE

2005	Board of Directors	Coalition for Health Services Research
2005	Editorial Board	Health Affairs
2004	Gubernatorial appointee	Governor's Panel on Health Reform, Louisiana
2002	Gubernatorial appointee	Governor's Action Group on Accessibility and Affordability of Health Insurance, State of Georgia
1999	Board of Directors	Louisiana Medical Mutual Insurance Company
1996	Vice Chairman	Louisiana Health Care Commission
1993-1995	Deputy Assistant Secretary for Health Policy	Department of Health and Human Services
1993-1994	Chair, Quantitative Impacts of Health Reform, President Clinton's Health Care Reform Task Force	The White House, Washington,
1991	Member	Institute of Medicine, Panel on 1992 the Future of Employer-Sponsored Health Benefits
1991	Consultant	National Leadership Coalition for Health Care Reform
1990	Member	Advisory Council on Social 1991 Security, Technical Panel on Future of Income Security and Medicare
1990	Gubernatorial Appointee	Massachusetts Commission on Health Care Financing

1989	Member	New York State Universal Health Insurance Advisory Council
1989	Consultant	Council on Health Care Financing, New York State Assembly, provided technical analysis and aided in design of New York's all-payer DRG hospital payment system
1985	Consultant	RAND/UCLA Center for Health Care Financing Policy
1980-1984	Graduate Fellow	The RAND Graduate School, RAND Corporation
1980	Staff Member	Human Resources & Community Development Division, Congressional Budget Office, Washington, D.C.
1979	Summer Staff Member	Office of Congressional Affairs

MAJOR INTERNATIONAL EXPERIENCE:

1995	Developed papers and provided technical assistance, and acted as a resource person for the Regional Conference on Health Sector Reform in Asia, at the Asian Development Bank, Manila, Philippines.
1994	US Representative to the Organization Economic Cooperation and Development (OECD) Conference on Health Care Reform. As Deputy Assistant Secretary for Health Policy was one of three US delegates working with OECD countries.
1985-1988	Visiting Professor, St. George's Medical School, St. Georges, Grenada, West Indies. Taught introductory health financing class to medical students. Provided technical assistance to hospitals and nursing homes in Grenada.

MAJOR VISITING APPOINTMENTS:

1981-1984	Adjunct Assistant Professor	Business and Management	Pepperdine University
1985	Visiting Assistant Professor	Graduate School of Business	Columbia University
1991	Adjunct Associate Research Professor	School of Medicine	Duke University

PUBLICATIONS

1. Thorpe KE. *"The Use of Relative Prices in DRG Payment Systems: Distributional Implications"*, Inquiry (Spring 1987).

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11. Thorpe KE, Siegel JE. *"Covering the Uninsured: Public Sector Impact of Employer Health Insurance Mandates and a Medicaid Buy-In"*, Journal of the American Medical Association (October 20, 1989).

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17. Thorpe KE, Spencer C. *"How Do Uncompensated Care Pools Affect the Level and Type of Care? Results from New York State"*, Journal of Health Politics, Policy and Law 16(2) (Summer 1991):363-381.

18. Epstein AM, Bogen J, Dreyer P, Thorpe KE. *"Trends in Length of Stay and Rates of Readmission in Massachusetts: Implications for Monitoring Quality of Care"*, Inquiry 28(l) (Spring 1991):19-28.

19. Thorpe KE. *"The National Health Insurance Conundrum: Shifting Paradigms and Potential Solutions"*, Journal of American Health Policy l(l) (Spring 1991):17-22.

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21. Thorpe KE, Gertler PJ, Goldman P. *"The Resource Utilization Group System: Its Effects on Nursing Home Case Mix and Costs",* Inquiry 28 (Winter 1991):357-365.

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by Subsidizing Employment-Based Health Insurance: Results from a Pilot Study", Journal of the American Medical Association 267(7) (February 19, 1992):945-948.

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Select Committee on Children, Youths and Families, December, 1989.

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RESEARCH AND PROFESSIONAL ACTIVITIES

MAJOR RESEARCH AND TEACHING INTERESTS:

National and State Health Care Policy

FUNDED RESEARCH AS PRINCIPAL INVESTIGATOR OR CO-INVESTIGATOR

Health Policy Options for Georgia, Georgia Health Care Foundation, principal investigator, $120,000, 2004-2005

Accountability and Health Safety-A Statewide Approach, Agency for Health Care Quality and Research*, principal investigator,* $1,606,430 *,* 2002-2005

"Developing New Options for Financing Cancer Care, Commonwealth Fund*, principal investigator,* $146,565, 2002

"Health Plan Selection for Medicare Eligible Enrollees in the FEHB", co-investigator, Robert Wood Johnson Foundation, $213,262, 2002.

"Contingent Workers and the Labor Market. Issues and Implications for Health Care Reform", The Commonwealth Fund, $25,000, 1999.

"The Impact of Hospital Ownership Changes in the Hospital Delivery System", Robert Wood Johnson Foundation, $509,156, 1997.

"The Impact of Managed Care on the Provision of Uncompensated Care", Kaiser Family Foundation, $150,000, 1997.

"Competitive Bidding in the Federal Employees Health Benefits Program", Robert Wood Johnson Foundation, $363,959, 1997.

"Factors Contributing to the Erosion and Shifts in Insurance Coverage of Working Families", The Commonwealth Fund, $151,329, 1995.

"Evaluation of State Risk Pools: The Current and Potential Experience", Robert Wood Johnson Foundation, $410,000, 1991.

"Does Managed Care Work? An Empirical Analysis of Corporate Cost Containment Initiative", Robert Wood Johnson Initiative, Robert Wood Johnson Foundation, $245,000, 1990.

"Impact of Utilization Review on Health Care Expenditures", Health Insurance Association of America, $220,000,1990.

"An Evaluation of the Impact of Subsidies on the Demand for Health Insurance", New York State Department of Health, 1989-1990, $400,000.

"Changes in the Financing of Health Care in New York State, 1989", The Commonwealth Fund and United Hospital Fund, $50,000.

"Impact of Private Sector Cost Containment Initiatives, 1989", US Department of Labor, $100,000.

"Payment Mechanisms and Nursing Home Outcomes", National Institute of Aging, 1988-1991, $370,000.

"Study of New York State Proposal to Restructure GME Training", New York State, 1988, $50,000.

"Expanding Medicaid: How Much Would It Cost? Health Care Agenda for the American People", American Medical Association, 1988, $50,000.

"Impact of the Resource Utilization Grouping 11 Reimbursement Program on Nursing Home Costs and Case Mix", Robert Wood Johnson Foundation, 1987, $245,000.

"Impact of the NYPHRM on Hospital Behavior", Robert Wood Johnson Foundation, 1985, $200,000.

REVIEWER FOR:

Journal of the American Medical Association
Journal of Health Economics
Journal of Health Politics, Policy and Law
Journal of Policy Analysis and Management
Inquiry
Law, Medicine and Health Care
American Economic Review
Medical Care
The New England Journal of Medicine
Health Services Research
Journal of Human Resources
Health Affairs

MEMBERSHIPS AND LICENSES

PROFESSIONAL SOCIETIES:

American Economic Association
Association for Public Policy Analysis and Management
American Public Health Association
Association for Health Services Research
Delta Omega Society

AWARDS AND HONORS

Herbert Goldhamer Award, Rand Graduate School, 1985
Awarded to top graduating doctoral student.

Young Investigator Award, Association for Health Services Research, 1991

Up and Comers Award, Modern Healthcare, 1993

Philip and Ruth Hettleman Award for Artistic and Scholarly Achievement, University of North Carolina at Chapel Hill, 1994

SERVICE

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Paying a Premium

The Added Cost of Care for the Uninsured

A REPORT BY

Families USA

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INTRODUCTION

This study quantifies, for the first time, the dollar impact on private health insurance premiums when doctors and hospitals provide health care to uninsured people. In 2005, premium costs for family health insurance coverage provided by private employers will include an extra $922 in premiums due to the cost of care for the uninsured; premiums for individual coverage will cost an extra $341.

Nearly 48 million Americans will be uninsured for the entire year in 2005. What happens when some of these 48 million Americans get sick? Research has shown that the uninsured often put off getting care for health problems—or forgo care altogether.[1] When the symptoms can no longer be ignored, the uninsured do see doctors and go to hospitals. Without insurance to pay the tab, the uninsured struggle to pay as much as they can: More than one-third (35 percent) of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves.[2]

To find out who pays the remainder of this bill—the portion that the uninsured themselves simply cannot manage to pay—Families USA contracted with Dr. Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management, Rollins School of Public Health, Emory University, to analyze data from the U.S. Census Bureau, the federal Agency for Healthcare Research and Quality, and the National Center for Health Statistics, and other data. Through this study, we found that the remaining $43 billion is primarily paid by two sources: Roughly one-third is reimbursed by a number of government programs, and *two-thirds is paid through higher premiums for people with health insurance.*

As the costs of care for the uninsured are added to health insurance premiums that are already rising steeply, more employers can be expected to drop coverage, leaving even more people without insurance. And as more people lose coverage and the cost of their care is added to premiums for the insured, still more employers will drop coverage. It's a vicious circle that will not end until we as a nation take steps to solve the underlying problems.

KEY FINDINGS

Health Insurance Premiums in 2005

- **Health insurance premiums for families who have insurance through their private employers**, on average, are $922 higher in 2005 due to the cost of health care for the uninsured that is not paid for by the uninsured themselves or by other sources of reimbursement (Table 1).

  In six states, health insurance premiums for families are at least $1,500 higher due to the unreimbursed cost of health care for the uninsured in 2005. These states are New Mexico ($1,875); West Virginia ($1,796); Oklahoma ($1,781); Montana ($1,578); Texas ($1,551); and Arkansas ($1,514) (Table 1).

- **Health insurance premiums for individuals who have insurance through their private employers**, on average, are $341 higher in 2005 due to the unreimbursed cost of health care for the uninsured (Table 1).

  In eight states, health insurance premiums for individuals are at least $500 higher due to the unreimbursed cost of health care for the uninsured in 2005. These states are New Mexico ($726); Oklahoma ($680); West Virginia ($660); Montana ($594); Alaska ($565); Arkansas ($560); Idaho ($551); and Texas ($550) (Table 1).

Health Insurance Premiums in 2010

- **By 2010, health insurance premiums for families who have insurance through their private employers**, on average, will be $1,502 higher in 2010 due to the unreimbursed cost of health care for the uninsured (Table 2).

  In 11 states, health insurance premiums for families will be at least $2,000 higher due to the unreimbursed cost of health care for the uninsured in 2010. These states are New Mexico ($3,169); West Virginia ($2,940); Oklahoma ($2,911); Texas ($2,786); Arkansas ($2,748); Alaska ($2,248); Florida ($2,248); Montana ($2,190); Idaho ($2,152); Washington ($2,144); and Arizona ($2,028) (Table 2).

- **Health insurance premiums for individuals who have insurance through their private employers**, on average, will be $532 higher in 2010 due to the unreimbursed cost of health care for the uninsured (Table 2).

  In eight states, health insurance premiums for individuals will be at least $800 higher due to the unreimbursed cost of health care for the uninsured in 2010. These states are New Mexico ($1,192); Oklahoma ($1,127); West Virginia ($1,037); Arkansas ($943); Texas ($922); Alaska ($857); Idaho ($820); and Montana ($807) (Table 2).

Costs of Uncompensated Care

- **In 2005, the cost of health care provided to people without insurance that is not paid out-of-pocket by the uninsured** themselves will exceed $43 billion nationally (Table 3).

  In 11 states, the cost of care that the uninsured cannot pay will exceed $1 billion in 2005. These states are California ($5.8 billion); Texas ($4.6 billion); Florida ($2.9 billion); New York ($2.7 billion); Illinois ($1.8 billion); Ohio ($1.4 billion); Pennsylvania ($1.4 billion); North Carolina ($1.3 billion); Georgia ($1.3 billion); New Jersey ($1.2 billion); and Michigan ($1.1 billion) (Table 3).

- **By 2010, the cost of health care provided to people without health insurance that is not paid out-of-pocket by the uninsured** will exceed $60 billion (Table 3).

  In 17 states, the cost of care that the uninsured cannot pay will exceed $1 billion in 2010. These states are California ($8.2 billion); Texas ($6.5 billion); Florida ($4.1 billion); New York ($3.8 billion); Illinois ($2.6 billion); Ohio ($2.0 billion); Pennsylvania ($2.0 billion); North Carolina ($1.9 billion); Georgia ($1.8 billion); New Jersey ($1.6 billion); Michigan ($1.6 billion); Virginia ($1.4 billion); Louisiana ($1.4 billion); Washington ($1.3 billion); Indiana ($1.3 billion); Arizona ($1.3 billion); and Tennessee ($1.2 billion) (Table 3).

Table 1

Impact of Health Care for the Uninsured on Health Insurance Premiums for Private Employer Coverage, by State, 2005

State	Premiums		Increase in Premiums Due to Health Care for the Uninsured	
	Individual	Family	Individual	Family
Alabama	$3,715	$9,695	$172	$449
Alaska	$4,155	$10,789	$565	$1,466
Arizona	$3,854	$10,454	$477	$1,293
Arkansas	$4,423	$11,947	$560	$1,514
California	$3,586	$10,973	$379	$1,160
Colorado	$4,340	$11,418	$355	$934
Connecticut	$3,870	$11,392	$198	$583
Delaware	$4,303	$10,726	$290	$724
Florida	$4,180	$11,723	$468	$1,313
Georgia	$3,770	$10,231	$275	$746
Hawaii	$3,173	$9,590	$208	$630
Idaho	$4,155	$10,789	$551	$1,432
Illinois	$4,445	$11,762	$400	$1,059
Indiana	$4,152	$10,618	$373	$953
Iowa	$3,993	$10,342	$200	$518
Kansas	$3,661	$10,874	$245	$729
Kentucky	$3,966	$11,176	$385	$1,086
Louisiana	$4,213	$10,993	$297	$776
Maine	$4,756	$12,204	$275	$705
Maryland	$4,105	$11,730	$332	$948
Massachusetts	$4,023	$10,617	$140	$370
Michigan	$4,225	$11,272	$274	$730
Minnesota	$4,309	$11,790	$141	$386
Mississippi	$3,669	$9,896	$277	$747
Missouri	$3,799	$10,063	$110	$291
Montana	$3,572	$9,483	$594	$1,578
Nebraska	$4,221	$11,292	$343	$918
Nevada	$4,248	$9,496	$490	$1,095
New Hampshire	$4,170	$13,323	$252	$805
New Jersey	$4,182	$11,966	$280	$802
New Mexico	$4,076	$10,524	$726	$1,875
New York	$4,044	$11,114	$233	$640
North Carolina	$4,097	$10,570	$438	$1,130
North Dakota	$4,155	$10,789	$355	$922
Ohio	$4,014	$10,948	$310	$847
Oklahoma	$4,417	$11,566	$680	$1,781
Oregon	$3,629	$11,009	$372	$1,128
Pennsylvania	$4,261	$10,495	$277	$681
Rhode Island	$4,155	$10,789	$19	$50
South Carolina	$3,995	$11,014	$202	$558
South Dakota	$4,155	$10,789	$386	$1,003
Tennessee	$3,686	$10,512	$272	$776
Texas	$4,210	$11,869	$550	$1,551
Utah	$3,643	$11,536	$263	$834
Vermont	$4,155	$10,789	$143	$372
Virginia	$3,625	$9,617	$277	$734
Washington	$4,276	$12,036	$428	$1,206
West Virginia	$4,372	$11,890	$660	$1,796
Wisconsin	$4,484	$11,392	$291	$739
Wyoming	$4,587	$11,068	$435	$1,050
Average	**$4,065**	**$10,979**	**$341**	**$922**

Table 2

Impact of Health Care for the Uninsured on Health Insurance Premiums for Private Employer Coverage, by State, 2010

State	Premiums		Increase in Premiums Due to Health Care for the Uninsured	
	Individual	Family	Individual	Family
Alabama	$5,470	$14,628	$343	$916
Alaska	$6,240	$16,365	$857	$2,248
Arizona	$5,899	$16,484	$726	$2,028
Arkansas	$7,373	$21,477	$943	$2,748
California	$5,005	$17,199	$521	$1,792
Colorado	$6,846	$18,659	$576	$1,570
Connecticut	$4,867	$16,726	$257	$882
Delaware	$6,589	$16,216	$440	$1,083
Florida	$6,333	$19,097	$746	$2,248
Georgia	$5,377	$15,599	$430	$1,246
Hawaii	$4,095	$13,624	$192	$640
Idaho	$6,240	$16,365	$820	$2,152
Illinois	$6,754	$18,149	$590	$1,586
Indiana	$6,224	$16,236	$573	$1,494
Iowa	$6,012	$16,293	$340	$921
Kansas	$5,326	$17,056	$365	$1,169
Kentucky	$6,105	$17,989	$619	$1,823
Louisiana	$6,545	$17,293	$491	$1,297
Maine	$7,544	$19,637	$446	$1,160
Maryland	$6,334	$18,905	$506	$1,510
Massachusetts	$5,451	$14,576	$212	$566
Michigan	$6,543	$18,214	$420	$1,170
Minnesota	$6,746	$18,842	$233	$650
Mississippi	$5,244	$15,622	$448	$1,335
Missouri	$5,670	$15,334	$225	$609
Montana	$4,932	$13,388	$807	$2,190
Nebraska	$6,659	$18,420	$530	$1,465
Nevada	$6,421	$14,461	$748	$1,685
New Hampshire	$6,275	$22,722	$375	$1,356
New Jersey	$5,755	$17,817	$406	$1,258
New Mexico	$6,520	$17,342	$1,192	$3,169
New York	$5,601	$16,743	$343	$1,024
North Carolina	$6,294	$16,727	$688	$1,828
North Dakota	$6,240	$16,365	$523	$1,371
Ohio	$6,217	$17,858	$485	$1,392
Oklahoma	$7,430	$19,186	$1,127	$2,911
Oregon	$5,247	$18,204	$544	$1,886
Pennsylvania	$6,489	$15,780	$426	$1,037
Rhode Island	$6,240	$16,365	$93	$245
South Carolina	$6,821	$18,671	$426	$1,167
South Dakota	$6,240	$16,365	$573	$1,504
Tennessee	$5,299	$16,328	$422	$1,299
Texas	$6,422	$19,404	$922	$2,786
Utah	$5,089	$19,923	$365	$1,431
Vermont	$6,240	$16,365	$230	$604
Virginia	$4,943	$13,765	$380	$1,057
Washington	$6,739	$20,908	$691	$2,144
West Virginia	$6,744	$19,120	$1,037	$2,940
Wisconsin	$6,778	$17,795	$426	$1,119
Wyoming	$7,278	$17,027	$722	$1,688
Average	**$6,115**	**$17,273**	**$532**	**$1,502**

Table 3

Cost of Health Care for the Uninsured Not Paid Out-of-Pocket by the Uninsured, by State

State	2005	2010
Alabama	$668,554,000	$935,975,000
Alaska	$124,786,000	$174,701,000
Arizona	$899,542,000	$1,259,359,000
Arkansas	$472,039,000	$660,854,000
California	$5,835,900,000	$8,170,260,000
Colorado	$713,725,000	$999,215,000
Connecticut	$352,684,000	$493,758,000
Delaware	$91,166,000	$127,633,000
Florida	$2,920,289,000	$4,088,405,000
Georgia	$1,305,077,000	$1,827,108,000
Hawaii	$148,477,000	$207,867,000
Idaho	$231,633,000	$324,286,000
Illinois	$1,846,383,000	$2,584,937,000
Indiana	$933,838,000	$1,307,374,000
Iowa	$322,929,000	$452,100,000
Kansas	$299,336,000	$419,070,000
Kentucky	$679,034,000	$950,648,000
Louisiana	$979,079,000	$1,370,711,000
Maine	$132,913,000	$186,078,000
Maryland	$712,838,000	$997,973,000
Massachusetts	$601,637,000	$842,292,000
Michigan	$1,133,109,000	$1,586,352,000
Minnesota	$373,290,000	$522,607,000
Mississippi	$498,943,000	$698,520,000
Missouri	$636,097,000	$890,535,000
Montana	$172,437,000	$241,412,000
Nebraska	$196,926,000	$275,697,000
Nevada	$396,881,000	$555,634,000
New Hampshire	$134,304,000	$188,025,000
New Jersey	$1,171,991,000	$1,640,788,000
New Mexico	$394,543,000	$552,360,000
New York	$2,732,796,000	$3,825,915,000
North Carolina	$1,340,006,000	$1,876,008,000
North Dakota	$70,229,000	$98,321,000
Ohio	$1,433,908,000	$2,007,472,000
Oklahoma	$681,481,000	$954,074,000
Oregon	$549,012,000	$768,616,000
Pennsylvania	$1,414,695,000	$1,980,572,000
Rhode Island	$102,813,000	$143,938,000
South Carolina	$606,595,000	$849,233,000
South Dakota	$96,669,000	$135,336,000
Tennessee	$832,107,000	$1,164,950,000
Texas	$4,617,127,000	$6,463,978,000
Utah	$271,728,000	$380,419,000
Vermont	$53,883,000	$75,437,000
Virginia	$995,357,000	$1,393,500,000
Washington	$948,359,000	$1,327,703,000
West Virginia	$376,497,000	$527,095,000
Wisconsin	$539,259,000	$754,962,000
Wyoming	$75,628,000	$105,879,000
Total*	**$43,118,528,000**	**$60,365,939,000**

* Numbers do not add due to rounding.

Uninsured People

- In 2005, nearly 48 million Americans will be uninsured for the entire year (Table 4).

  California is the state with the largest *number* of uninsured people in 2005 (7.1 million people are uninsured for the entire year), followed by Texas (5.9 million); New York (3.3 million); Florida (3.1 million); and Illinois (2.0 million) (Table 4).

  Texas is the state with the highest *percentage* of uninsured people in 2005 (26.2 percent uninsured for the entire year), followed by New Mexico (22.1 percent); Nevada (20.5 percent); Alaska (20.0 percent); and California (19.6 percent) (Table 4).

- In 2010, the number of Americans who will be uninsured for the entire year will be nearly 53 million (Table 5).

  California is projected to have the largest *number* of uninsured people in 2010 (7.8 million uninsured for the entire year), followed by Texas (6.4 million); New York (3.7 million); Florida (3.6 million); and Illinois (2.1 million) (Table 5).

  Texas is projected to have the highest *percentage* of uninsured people in 2010 (27.4 percent were uninsured for the entire year), followed by New Mexico (23.5 percent); Nevada (21.9 percent); California (20.6 percent); and Alaska (20.6 percent) (Table 5).

Table 4

Uninsured Population in 2005, by State

State	Total Population	Number of Uninsured	Percent Uninsured
Alabama	4,538,000	590,000	13.0%
Alaska	661,000	132,000	20.0%
Arizona	5,717,000	973,000	17.0%
Arkansas	2,738,000	453,000	16.5%
California	36,284,000	7,122,000	19.6%
Colorado	4,593,000	781,000	17.0%
Connecticut	3,507,000	414,000	11.8%
Delaware	841,000	86,000	10.2%
Florida	17,346,000	3,141,000	18.1%
Georgia	8,787,000	1,443,000	16.4%
Hawaii	1,285,000	158,000	12.3%
Idaho	1,394,000	258,000	18.5%
Illinois	12,946,000	1,961,000	15.1%
Indiana	6,303,000	865,000	13.7%
Iowa	2,995,000	297,000	9.9%
Kansas	2,751,000	314,000	11.4%
Kentucky	4,214,000	601,000	14.3%
Louisiana	4,541,000	886,000	19.5%
Maine	1,315,000	161,000	12.3%
Maryland	5,631,000	790,000	14.0%
Massachusetts	6,527,000	740,000	11.3%
Michigan	10,167,000	1,252,000	12.3%
Minnesota	5,204,000	424,000	8.1%
Mississippi	2,926,000	509,000	17.4%
Missouri	5,765,000	702,000	12.2%
Montana	940,000	151,000	16.1%
Nebraska	1,771,000	191,000	10.8%
Nevada	2,307,000	473,000	20.5%
New Hampshire	1,296,000	137,000	10.5%
New Jersey	8,795,000	1,344,000	15.3%
New Mexico	1,918,000	425,000	22.1%
New York	19,447,000	3,342,000	17.2%
North Carolina	8,460,000	1,472,000	17.4%
North Dakota	647,000	76,000	11.7%
Ohio	11,530,000	1,446,000	12.5%
Oklahoma	3,525,000	635,000	18.0%
Oregon	3,659,000	555,000	15.2%
Pennsylvania	12,460,000	1,495,000	12.0%
Rhode Island	1,080,000	121,000	11.2%
South Carolina	4,167,000	561,000	13.5%
South Dakota	770,000	95,000	12.3%
Tennessee	6,058,000	680,000	11.2%
Texas	22,408,000	5,880,000	26.2%
Utah	2,412,000	342,000	14.2%
Vermont	627,000	71,000	11.4%
Virginia	7,572,000	1,078,000	14.2%
Washington	6,244,000	971,000	15.6%
West Virginia	1,832,000	285,000	15.6%
Wisconsin	5,566,000	593,000	10.7%
Wyoming	500,000	94,000	18.8%
Total*	**294,963,000**	**47,564,000**	
Average			**16.1%**

* Numbers do not add due to rounding.

Table 5

Uninsured Population in 2010, by State

State	Total Population	Number of Uninsured	Percent Uninsured
Alabama	4,744,000	654,000	13.8%
Alaska	691,000	143,000	20.6%
Arizona	5,976,000	1,096,000	18.3%
Arkansas	2,862,000	496,000	17.3%
California	37,930,000	7,826,000	20.6%
Colorado	4,801,000	857,000	17.8%
Connecticut	3,666,000	475,000	12.9%
Delaware	879,000	99,000	11.3%
Florida	18,133,000	3,555,000	19.6%
Georgia	9,185,000	1,600,000	17.4%
Hawaii	1,343,000	177,000	13.2%
Idaho	1,457,000	283,000	19.4%
Illinois	13,533,000	2,149,000	15.9%
Indiana	6,589,000	950,000	14.4%
Iowa	3,131,000	328,000	10.5%
Kansas	2,875,000	347,000	12.1%
Kentucky	4,405,000	668,000	15.2%
Louisiana	4,747,000	971,000	20.5%
Maine	1,374,000	182,000	13.3%
Maryland	5,886,000	871,000	14.8%
Massachusetts	6,824,000	846,000	12.4%
Michigan	10,629,000	1,360,000	12.8%
Minnesota	5,440,000	480,000	8.8%
Mississippi	3,058,000	559,000	18.3%
Missouri	6,026,000	773,000	12.8%
Montana	982,000	166,000	16.9%
Nebraska	1,851,000	211,000	11.4%
Nevada	2,411,000	529,000	21.9%
New Hampshire	1,355,000	156,000	11.5%
New Jersey	9,194,000	1,502,000	16.3%
New Mexico	2,005,000	472,000	23.5%
New York	20,329,000	3,698,000	18.2%
North Carolina	8,844,000	1,624,000	18.4%
North Dakota	677,000	84,000	12.5%
Ohio	12,053,000	1,583,000	13.1%
Oklahoma	3,684,000	690,000	18.7%
Oregon	3,825,000	607,000	15.9%
Pennsylvania	13,026,000	1,661,000	12.7%
Rhode Island	1,129,000	140,000	12.4%
South Carolina	4,356,000	631,000	14.5%
South Dakota	805,000	106,000	13.2%
Tennessee	6,332,000	771,000	12.2%
Texas	23,424,000	6,427,000	27.4%
Utah	2,521,000	378,000	15.0%
Vermont	655,000	80,000	12.2%
Virginia	7,915,000	1,186,000	15.0%
Washington	6,527,000	1,065,000	16.3%
West Virginia	1,915,000	316,000	16.5%
Wisconsin	5,818,000	657,000	11.3%
Wyoming	523,000	102,000	19.5%
Total*	**308,342,000**	**52,586,000**	
Average			**17.1%**

* Numbers do not add due to rounding.

DISCUSSION

This study projects that there will be nearly 48 million people in the United States who will be uninsured for the entire year during 2005 (Table 4) and that there will be nearly 53 million people uninsured for the entire year in 2010 (Table 5). These projections are based on data on the uninsured provided annually by the U.S. Census Bureau's Current Population Survey (CPS) and by other federal government databases.

Some of these uninsured people will become sick and will need health care. What happens then? Certainly, the uninsured are much less likely to receive health care, and many never do. When the uninsured do receive health care they can't afford to pay for themselves, how do our health care system and our society pay for this care? While the answer is multifaceted, this report shines a spotlight on *how much* those of us lucky enough to have health insurance—and our employers—will pay in higher health insurance premiums to cover the cost of health care for the uninsured. This report provides, for the first time, state-by-state estimates of the dollar impact of the cost of health care for the uninsured on private, employer-sponsored health insurance premiums.

Who Are the Uninsured?

Contrary to popular belief, the overwhelming majority of uninsured people are workers or members of a family in which at least one member works. Researchers have estimated that four in five individuals without health insurance are employed or in a family with an employed adult.[3]

There are several reasons why people with jobs lack health insurance. *First*, not all jobs offer health insurance benefits. The likelihood that an employer offers health benefits to its workers varies considerably. Small employers, employers with low-wage workers, and employers with older workers are all less likely to be able to afford to offer health coverage to their employees. *Second,* some people who are offered coverage by their employer do not sign up for that coverage because they cannot afford to pay the portion of the premium that is not paid by their employer. In 2004, full-time workers re-

ceiving employer-sponsored health insurance were asked to pay, on average, $564 per year in premiums for individual coverage and $2,664 per year in premiums for family coverage.[4] Paying the employee share of the premium is particularly difficult for low-wage workers. Recent research from California shows that a worker's share of premiums can account for as much as 46 percent of full-time wages for minimum-wage workers.[5]

Other uninsured people are workers who have recently lost their jobs due to layoffs or other factors beyond their control. As the workforce becomes increasingly mobile, we can expect more and more workers to experience periods of joblessness and, thus, temporary loss of insurance. Some workers who lose employer-based health insurance are eligible to remain temporarily on their former employer's plan through the federal COBRA statute or a state COBRA-like law affecting small employers.[6] However, the costs of such coverage are usually prohibitive: An unemployed worker must pay the employer's full costs for such coverage plus a 2 percent administrative fee. The national average cost of employer-provided family coverage in 2005 will be about $11,000 annually (Table 1) and will rise to more than $17,000 annually in 2010 (Table 2). Thus, while it is not unusual to have a gap of time between jobs in today's work world, these gaps also leave workers and their families without insurance coverage and, thus, at serious health and financial risk.

Some working uninsured do try to purchase health insurance coverage in the private, individual market. However, the cost of purchasing health insurance coverage in this market is often prohibitively high and the coverage less than adequate—and, for many people in less-than-perfect health, no offers of coverage are available at all.[7]

Many people wrongly assume that Medicaid, a national program designed to insure those with low incomes, is available to help low-wage, uninsured workers. Medicaid is really 51 different programs run by the states and the District of Columbia with 51 different sets of rules about who is eligible for coverage, different income guidelines, and different enrollment procedures.

In almost all states, Medicaid income eligibility differs based on family status. In 42 states, adults who do not have dependents can never qualify for Medicaid or any other public coverage, no matter how poor they are. In

most states, a child is eligible for public health coverage (through either Medicaid or SCHIP—the State Children's Health Insurance Program) if that child's family income is below 200 percent of the federal poverty level ($32,180 for a family of three in 2005). For parents, the income eligibility levels are much lower than they are for children. The median income eligibility limit for parents among the 50 states is about 70 percent of the federal poverty level—only a little more than $11,000 in annual income for a family of three.[8] A parent in a family of three working full-time all year at minimum wage would earn "too much" to qualify for Medicaid in half the states (even though the family's annual income is below the poverty level).

What Happens When the Uninsured Need Health Care?

Previous reports by Families USA and others have highlighted extensive research documenting the negative effects of being uninsured. There is no question that uninsured Americans forgo or delay critical health care because they lack health insurance coverage.[9]

First, we know that uninsured people often do not receive health care when they need it. Shockingly, every year, the deaths of 18,000 people between the ages of 25 and 64 can be attributed to a lack of health insurance.[10] Almost half (49 percent) of uninsured adults with chronic conditions forgo needed medical care or prescription drugs due to cost. Uninsured adults with chronic conditions are 4.5 times more likely than their insured counterparts to report an unmet need for medical care or prescription drugs.[11] Uninsured adults are three to four times more likely than insured adults to go without preventive services, such as screening for hypertension or breast cancer.[12] Uninsured children are nearly eight times less likely to have a regular source of care than insured children.[13]

Second, we know that uninsured people delay seeking medical care and end up sicker when they do go for care. More than one in four (27 percent) uninsured adults with chronic conditions reported *no* visits to a health professional in the past year.[14] Uninsured adults have a greater chance of experiencing a major health decline than insured adults.[15] When hospitalized, uninsured

patients are likely to be in worse condition than insured patients,[16] and they are three times more likely to die in the hospital than insured patients.[17]

To pay for their health care, the uninsured use up all their savings, borrow money from family and friends to pay for costs up front, work more than one job, charge credit cards for large bills that will take years to repay, or take out a loan or mortgage on their home.[18] When those resources are gone, the uninsured are often forced to skip utility bills, cut other family expenses, and even cut back on the family food budget.[19] Eventually, many uninsured people are forced to file for bankruptcy due to medical bills; about half of all personal bankruptcy cases are due to medical reasons.[20] Even after making tremendous personal sacrifices, the contributions made by uninsured people toward their medical bills cover an estimated 35 percent of the cost of care they receive from doctors and hospitals.[21]

Who Pays for Health Care for the Uninsured?

To develop an estimate of the cost of care that the uninsured receive and cannot afford to pay ("uncompensated care"), our study adjusts the total charges to the uninsured to reflect what the privately insured would pay, on average, in the state for the same health care services. We do this in order to avoid inappropriately inflating the value of the health care services and to ensure that our estimate of what providers will need to recoup is a conservative one. Research has shown that uninsured patients are charged much more than insurance companies are charged for the same services.[22]

Nationally, we estimate that about $43.1 billion in health care for which the uninsured cannot afford to pay will be provided by hospitals and doctors in 2005. In 2010, about $60.4 billion in uncompensated care will be provided (see Table 3). (These estimates do *not* include uncompensated care provided to *insured* people, who may be unable to pay because they face high deductibles, high copayments, uncovered services, and other out-of-pocket costs that people with insurance are sometimes unable to pay.[23])

These costs are covered by the following three sources:

1. non-patient, non-government revenue sources, including philanthropy;
2. federal, state, and local programs that partially reimburse providers for the cost of care to the uninsured; and
3. higher premiums for people with private health insurance.

The contribution that philanthropy makes toward paying for care for the uninsured is minimal. Based on our analysis of data from the Medical Expenditure Panel Survey, philanthropy is estimated to cover only 1 to 2 percent of the cost of this care.[24]

The combined contribution of federal, state, and local programs that partially reimburse providers for the cost of care to the uninsured accounts for approximately one-third of the uncompensated care provided by both hospitals and physicians nationally (see Appendix Tables 1 and 2). This comes to 33 percent in 2005 and 29 percent in 2010. This government support includes Medicaid and Medicare Disproportionate Share Hospital (DSH) payments from the federal government and various state and local government programs. Thus, uncompensated care is partially financed by all of us who pay federal, state, and local taxes. In 2005, we will collectively pay more than $14 billion in taxes that support programs that help pay for health care for the uninsured. In 2010, if our federal, state, and local governments continue their commitment to helping the uninsured, the total dollars in taxes paid will rise to more than $17 billion (see Appendix Tables 1 and 2).

But that leaves two-thirds of the cost of uncompensated care unpaid—a gap that is filled by patients with private health insurance. We estimate that almost $29 billion worth of unpaid care received by the uninsured in 2005 and more than $43 billion in 2010 will be financed by higher premiums for privately insured patients. As a result, the cost of private insurance will be, on average in the nation, 8.5 percent higher in 2005 than it would be if everyone in the United States were to have health insurance. This translates into $341 more for the average individual premium and $922 more for the average family premium (see Table 1 and Appendix Table 1). In 2010, the annual impact will be 8.7 percent ($1,502 more for the average family premium and $532 more for the average individual premium). (See Table 2 and Appendix Table 2.)

How Does This Happen?

How does the cost of care for the uninsured end up being passed on in the form of higher private health insurance premiums? The cost of care not otherwise directly paid for by the uninsured or by government programs or philanthropy is built into the cost base of physician and hospital revenue. Providers attempt to recover these "uncompensated care" dollars through various strategies; one key strategy is to negotiate higher rates for health care services paid for by private insurance. The extent to which providers can do this varies from state to state; nonetheless, the rates always reflect a significant amount of uncompensated care. Given that most health care providers are not driven to bankruptcy and our health care system survives from year to year, we can say with certainty that those with health insurance finance the residual two-thirds of the cost of care for the uninsured provided by a state's hospitals and doctors. Ironically, this increases the cost of health insurance and results in fewer people who can afford insurance—a vicious circle.

The state-to-state variation in the impact on premiums of care for the uninsured can be explained by a number of factors. The first factor is the percent of the population that is uninsured in the state (see Tables 4 and 5). This percentage, in turn, is related to the demographics of the state, the mix of types of employment in the state, and the income eligibility levels of the state's Medicaid program.

Another important factor is the dollar amount that federal, state, and local programs pay to offset the cost of care received by uninsured people and the percentage of these total costs borne by the combination of government programs (see Appendix Tables 1 and 2).

Other factors that help to explain the variation among states include: 1) the number of "safety net" health care providers (community health centers and public teaching hospitals, for example) that serve the uninsured as part of their mission, which affects the average level of services provided in a state per uninsured person; 2) the cost of these services to the uninsured (which, under our methodology, is based on average private insurance rates and thus is related to the competitive health environment in the state and how much leverage providers have to negotiate rates with insurers); and 3) the aggressiveness of debt collection practices by providers serving the uninsured and the protections in state law to prevent the most egregious debt collection practices.

More Insured = More Productivity = A Stronger Economy

While this report focuses on how care for the uninsured affects the health insurance premiums we pay—its *micro*economic impact—there also are implications for the nation's economy as a whole—a *macro*economic impact. Economists estimate that between $65 and $130 billion of productivity is lost each year due to uninsurance in America.[25]

- Insured employees are healthier.[26] Better health, in turn, is related to increased productivity.[27] In addition, providing health insurance ensures that employees have access to primary and preventive care that keeps them healthy and productive in the long run.[28]
- Insured workers are absent less and are more productive when they're on the job. In fact, one study showed that providing health insurance alleviates one in 10 days missed for illness.[29] Three in four employers believe that health benefits are extremely, very, or somewhat important for improving employee productivity.[30]
- Health insurance reduces turnover. The cost of hiring and training new employees drains business productivity. Many studies show that workers with health insurance change jobs less frequently.[31] Nearly three-quarters of workers said that health insurance was a "very important" factor in their decision to take or keep a job.[32]
- Matching the right worker with the best job for his/her skills maximizes productivity. Three out of four employers say that providing health insurance assists in recruiting the right employee for the job and helps to retain employees.[33] Economists assert that when some small employers cannot afford to offer health insurance coverage (or only offer inferior coverage), our economy's labor market is negatively distorted.[34]
- The fear of going without health insurance discourages individuals from starting new businesses on their own. When this entrepreneurial spirit is dampened, the new ideas, new products, and new competitiveness that new business brings to the economy are lost and productivity is hurt.[35]
- Health insurance reduces the risk of medical bankruptcy, which hurts both individuals and their creditors.[36] When the efficient free market flow of dollars for goods and services is altered by bankruptcy, the productivity of the economy is hurt.
- A well-educated workforce increases productivity. Today's children are the key to the productivity of tomorrow's workforce. Providing health insurance to children helps them reach their full potential. Insured children are less likely to have developmental delays that may affect their ability to learn.[37] Improving health improves educational attainment and increases earnings potential by 10 to 30 percent.[38]

CONCLUSION

Common sense and extensive research already tell us that going without health insurance profoundly affects both the physical and economic well-being of *uninsured* Americans: They literally pay the price of being uninsured with their lives. What we have shown in this study is that we are all affected by the presence of large numbers of Americans without health insurance. Unless we find realistic ways to help the uninsured get coverage, the problem can be expected to worsen—for the uninsured and the insured alike.

ENDNOTES

[1] The Urban Institute and the University of Maryland, Baltimore County, *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey* (Washington: Robert Wood Johnson Foundation, May 2005); Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured, A Review of the Research on the Relationship between Health Insurance, Health, Work, Income and Education* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2002); Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington: National Academy Press, 2002); Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington: National Academy Press, 2001); American College of Physicians-American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick* (Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999).

[2] This figure is based on an analysis of the federal Medical Expenditure Panel Survey-Household Component (MEPS-HC) and is consistent with the analyses of MEPS-HC done by other researchers. It is the average contribution of people who are uninsured for a full year. See Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" *Health Affairs, Web Exclusive*, February 12, 2003, pp. W3-66 – W3-81, at p. W3-70. See also Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 10, 2004).

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[4] Gary Claxton and Jon Gabel, Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits, 2004 Annual Survey* (Washington: Kaiser Family Foundation, 2004).

[5] California HealthCare Foundation, *Health Insurance: Can Californians Afford It?* (Oakland, CA: California HealthCare Foundation, 2005), available online at http://www.chcf.org/documents/insurance/HealthInsuranceAffordability.pdf.

[6] Federal COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) legislation requires that many employers allow former workers—if they are willing and able to pay the full cost of coverage—to remain in the employer's group health plan for a period of time. COBRA provides 18 months of continuation coverage to workers laid off from firms with 20 or more employees. COBRA allows such workers to continue health coverage not merely for themselves, but for their family members as well. See U.S. Department of Labor, Pension and Welfare Benefits Administration, *Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)* (Washington: U.S. Department of Labor, August 2002), available online at http://www.dol.gov/ebsa/pdf/cobra99.pdf. In addition, 38 states have enacted COBRA-like laws that supplement the federal law by requiring varying periods of access to continuation coverage for workers laid off from firms with fewer than 20 employees. See Kathleen Stoll, *More than 725,00 Laid-Off Workers Have Lost Health Coverage Since the Recession Began in March*, Special Report (Washington: Families USA, December 2001).

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[8] See Marc Steinberg, *Working without a Net: The Health Care Safety Net Still Leaves Millions of Low-Income Workers Uninsured* (Washington: Families USA, April 2004). The eligibility levels presented in this report were adjusted to reflect 2005 federal poverty levels.

[9] Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, op. cit; Institute of Medicine, *Coverage Matters: Insurance and Health Care*, op. cit.

[10] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington: National Academy Press, 2003).

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[21] This figure is based on an analysis of the federal Medical Expenditure Panel Survey-Household Component (MEPS-HC) and is consistent with the analyses of MEPS-HC done by other researchers. It is the average contribution of people who are uninsured for a full year. See Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" op. cit. See also Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update*, op. cit.

[22] Gerard Anderson, *A Review of Hospital Billing and Collection Practices, Testimony before the Subcommittee on Oversight and Investigations*, Committee on Energy and Commerce, U.S. House of Representatives, June 24, 2004, available online at www:energycommerce.house.gov/108/Hearings/06242004hearing1299/Anderson2095.htm. See also *Why the Working Poor Pay More: A Report on the Discriminatory Pricing of Health Care* (Washington: Hospital Accountability Project of the Service Employees International Union, March 2003); Irene Wielawski, "Gouging the Medically Uninsured: A Tale of Two Bills," *Health Affairs*, vol. 19, no. 5, September/October 2000.

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[24] Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" op. cit. Philanthropy is estimated to contribute between 0.8 and 1.6 percent of the cost of uncompensated care provided by hospitals.

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APPENDIX:

METHODOLOGY

METHODOLOGY

Families USA contracted with Dr. Kenneth E. Thorpe to quantify, nationally and in each state, the impact of uncompensated health care received by the uninsured population on private, employer-sponsored health insurance premiums.

Uncompensated care is care that uninsured people receive from health care providers but which the uninsured do not pay for themselves. Our analysis of data, as well as other research, has established that, nationally, about 35 percent of the cost of the care that the uninsured receive from doctors and hospitals is paid for by the contributions of the uninsured themselves.[1] Federal, state, and local programs pay about a third of the remaining unpaid cost. The residual two-thirds of uncompensated care costs are passed on to people with private insurance through higher premiums.

About the Researcher

Dr. Thorpe is the Robert W. Woodruff Professor and Chair of the Department of Health Policy & Management in the Rollins School of Public Health of Emory University, Atlanta, Georgia. He was a Vanselow Professor of Health Policy and Director, Institute for Health Services Research. Dr. Thorpe received his Ph.D. from the RAND Graduate School, an M.A. from Duke University, and his B.A. from the University of Michigan. He was previously Professor of Health Policy and Administration at the University of North Carolina at Chapel Hill, Associate Professor and Director of the Program on Health Care Financing and Insurance at the Harvard University School of Public Health, and Assistant Professor of Public Policy and Public Health at Columbia University. Dr. Thorpe has also held visiting faculty positions at Pepperdine University and Duke University. Most recently, Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services.

About the Research Methodology

■ Numbers of Uninsured and Insured

For the out years 2005 and 2010, we used the same statistical analysis to predict the number of insured and the number of uninsured for the entire year. We started with a regression analysis of data between 1996 and 2003, using an indication of whether the person was insured. We included several control variables in the model to predict insurance status—these included income, the cost of health

care, and other key predictors of insurance status. With the model, we substituted projected values of these key variables for each of the states using projections from both the Centers for Medicare and Medicaid Services (CMS) and the Congressional Budget Office (CBO) to project the growth in insured and uninsured. We used a methodology very similar to Gilmer and Kronick,[2] and our results are similar. The steps to complete the calculation of the number of insured and the number of uninsured for 2005 and 2010 are:

1. Pool March CPS 1996 to March CPS 2003.
2. Merge in state health accounts data containing average health expenditures by state.
3. Project CPS income to 2005 and 2010 dollars using CBO projected growth in CPI.
4. Merge in state unemployment data. Project unemployment rate to 2005 and 2010 using CBO projections.
5. Use Census data to project race/ethnicity composition for 2005 and 2010. (http://www.census.gov/ipc/www/usinterimproj/)
6. Regress privately insured on health expenditures as a percent of income, education, race/ethnicity, time trend, family structure, and unemployment rate.
7. Predict privately insured for 2005 using 2005 projected values for race/ethnicity, unemployment, and health expenditures as a percent of income.
8. Predict privately insured for 2010 using 2010 projected values for race/ethnicity, unemployment, and health expenditures as a percent of income.

Uncompensated Care

In order to measure and quantify the impact of cost of care for the uninsured on private insurance premiums, we first developed a national estimate of uncompensated care and then applied this estimate to the 50 states. The estimates included all uncompensated care provided to the uninsured—by hospitals, physicians, and other health care providers. (See the second column, "Total Health Care for the Uninsured Not Paid by the Uninsured," in Appendix Tables 1 and 2.)

Based on the Medical Expenditure Panel Survey-Household Component (MEPS-HC) for the year 2002, and using methods similar to those developed by Jack Hadley and John Holahan,[3] we developed an estimate of uncompensated care.

In order for our analysis to examine the provision of uncompensated care in each of the 50 states, we developed simulation models that link two important federal data sets—the Medical Expenditure Panel Survey-Household Component (MEPS-HC) and the Current Population Survey (CPS). While some states do collect information on uncompensated care provided by hospitals, there are no existing comprehensive tabulations of uncompensated care provided by all providers in a state.

The MEPS is a nationally representative survey of the non-institutionalized population that provides detailed information on insurance coverage, health care spending, and other demographic and financial information. The most recent data are for 2002. Using the MEPS, we developed a statistical model that predicts spending by the uninsured while accounting for several important factors, including:

- age,
- family income,
- education,
- health status, and
- employment status (full-time, full year; part-time, part year; full-time, part year; and part-time, part year).

Based on this model, we adjusted the predictions for the amount of spending that is uncompensated (not paid for by the uninsured who receive the care).

Using this statistical model, we applied the results to the entire CPS sample using the March 2004 CPS. By plugging in the characteristics of the uninsured in the CPS (age, family income, education, health status, and employment), we allocated the national uncompensated care cost across the 50 states based on the actual characteristics of the uninsured in each state. This allowed us to develop several tabulations of the uninsured by state, as well as by age, employment status, income, and health status.

We "aged" the MEPS data to 2005 using trend factors from CMS.

It is important to note that our methodology for estimating the cost of uncompensated care does not rely on the amount that hospitals or providers charge the uninsured for their health care services. Rather, in order to avoid inappropriately inflating the value of the health care services, and to ensure that our estimate of what providers will need to recoup is a conservative one, we adjusted the total charges to the uninsured to reflect what the privately insured would pay, on average, in the state for the same health care services. This estimate is based on a question from the MEPS that asks "How much would providers have been paid if the uninsured

had been covered by private insurance?" Following a previous estimate made by Jack Hadley and John Holahan, the difference between the per capita spending among the uninsured (which will exclude spending financed by private or public insurance during periods of the year they may have insurance) provides an estimate of uncompensated care.

The steps to complete the calculation of uncompensated care are:

1. Calculate payment-to-charge ratios for full-year privately insured from MEPS 2002.
2. Multiply MEPS expenditure and charge data by an adjustment factor of 1.25 to be in agreement with National Health Accounts numbers used by CMS.
3. Determine total health care charges for the uninsured based on the MEPS-HC.
4. Adjust total charges by multiplying payment-to-charge ratio for privately insured times total charges.
5. Uncompensated care equals adjusted total charges minus the sum of total private, total public, and total out-of-pocket expenditures for the uninsured. Our tabulations largely match those from the Hadley and Holahan study nationally.
6. Increase uncompensated care by a growth factor of 1.25 to get projected uncompensated care for 2005 and by 1.75 for 2010. These trends factors are based on CMS projections of the growth in private health insurance spending.
7. Using MEPS 2002, develop a statistical model to apportion the national levels of uncompensated care across each of the 50 states. We do this by using the MEPS data and through regression analysis, regress uncompensated care (per each uninsured person in the sample) on age, gender, race/ethnicity, firm size, poverty level, and number of months uninsured. This also is done for national uncompensated care in 2005 and 2010.
8. Using the results from this model, collect the same independent variables from the Current Population Survey (March 2004) for each CPS uninsured person and predict uncompensated care. Since the CPS identifies residence, we are able to sum uncompensated for each person in each of the 50 states. We do this by applying coefficients to March CPS 2004 to get state-level estimates of uncompensated care for 2005 and 2010.

Uncompensated Care Financing

First, "unsponsored care" was determined by subtracting Medicaid disproportionate share hospital (DSH) payments, Medicare DSH payments, and state and local dollars from programs that pay for the care of the uninsured from total uncompensated care.

We compiled data from CMS on Medicare and Medicaid DSH spending by state. We exclude Medicaid DSH payments that are paid directly to mental hospitals in our totals. These dollars are not used to finance uncompensated care, but they are used to cover institutionalized mental health services.

Medicaid DSH figures for 2005 and 2010 were estimated using the following methodology: First, we applied the percentage distribution (by state) of 2003 DSH payments as reported by CMS to the $8.7 billion in national Medicaid DSH funding in 2004 (as reported by CBO) to determine 2004 DSH payments on a state-by-state basis. Next, we trended forward these 2004 DSH payments by the projected growth factor determined by CBO for each given year from 2005 through 2010.

Since we only had a national number for projected Medicare DSH payments in 2005 and 2010, we had to estimate the state-by-state distribution of these Medicare DSH dollars. To do so, we took the national amount of projected Medicare DSH (as projected by CBO) for 2005 and for 2010 and distributed these amounts by state according to its percentage of the total count of people 65 years or older who received Medicaid. These counts were based on the March 2004 CPS.

In addition, using data from the American Hospital Association Annual Surveys, we developed state-level estimates of state and local tax appropriation payments to hospitals for each state.

To estimate the state and local tax levy payments for 2005 and 2010, we first relied on the American Hospital Association's *Annual Survey Databank* to estimate an average annual growth rate on a state-by-state basis. Using the 1990 and 1999 data (the most recently available data on this variable) for tax appropriations of community hospitals, we determined an average annual growth rate. We then applied the percentage distribution by state to the 2001 national tax appropriation aggregate number for community hospitals as determined by Hadley and Holahan. Finally, we grew this 2001 number by the average annual growth rate to obtain the 2005 and 2010 estimates of state and local tax levies paid to community hospitals.

The above series of steps used to collect and trend forward Medicaid DSH, Medicare DSH, and state and local support of care to the uninsured allowed us to determine, nationally and for each state, a dollar figure for "unsponsored care"—the residual amount of uncompensated care that is not paid for by these major sources of funding for the uninsured. (See the third and fourth columns in Appendix Tables 1 and 2 showing total dollar support from these government programs and the residual unsponsored care for each state and nationally.)

This residual amount is built into the cost base of physician and hospital charges. In other words, providers attempt to recover these dollars by targeting approaches for increasing total private insurance payments for services. The ability to adjust the various rates for health care services that providers charge after negotiation with insurance companies and employers varies from state to state; nonetheless, the rates always reflect a significant portion of uncompensated care.

Second, to measure and quantify the impact of this transfer of costs on private, employer-sponsored premiums, we determined the cost of average private health insurance premiums for single and family policies by state. We were then able to estimate the impact on private health insurance premiums linked to the cost of unsponsored care.

To determine the average private insurance premium for single and family policies in 2005 and 2010, we used data from the *Medical Expenditure Panel Survey*'s Table II Series, "Private-Sector Data by Firm Size and State." Specifically, we looked at the average total single and family premiums per enrolled employee at private-sector establishments that offer health insurance by firm size and state in 1996 and 2002. Using those endpoints to determine a trend factor, we then projected 2002 figures forward to 2005 and 2010 (see the fifth column, "Total Premiums for Private, Employer-Sponsored Health Insurance," in Appendix Tables 1 and 2).

We determined the markup on private insurance premiums for 2005 and 2010 in several steps and employed the same methodology for both years. First, we developed an estimate of per capita (for children and adults) health care spending among those with employer-sponsored (both public and private employees) insurance (ESI) and individually purchased insurance. The standard actuarial approach is to take the single premium (for each state) and multiply it by 0.82 (this reflects the mix of children and adults and provides an overall per capita estimate). Next, within each state, we multiplied this figure by its number of people with ESI and

individual coverage. This provides an estimate of total health care spending among those with ESI and individual coverage in each state. This total is our denominator. The numerator is unsponsored care—that care that is not directly paid from government (unsponsored care is uncompensated care minus Medicaid DSH, Medicare DSH, and state and local levies). Dividing unsponsored care by expenditures made by the privately insured determines the premium markup in each state on private health insurance premiums due to subsidizing uncompensated care (see the last column, "Markup on Private Health Insurance Premiums Due to Health Care for the Uninsured," in Appendix Tables 1 and 2).

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[1] This figure is based on analysis of the federal Medical Expenditure Panel Survey-Household Component (MEPS-HC) and is consistent with the analyses of MEPS-HC by other researchers. See Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 10, 2004). See also Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" *Health Affairs, Web Exclusive*, February 12, 2003, pp. W3-66 – W3-81, at p. W3-70.

[2] Todd Gilmer and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured through 2013," *Health Affairs, Web Exclusive*, April 5, 2005, pp. W5-143 – W5-151, at pp. W5-144 – W5-145.

[3] Jack Hadley and John Holahan, The *Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update,* op.cit.

APPENDIX:

TABLES

Appendix Table 1

2005 Health Care Costs for the Uninsured, by State

State	Total Health Care for the Uninsured Not Paid by the Uninsured [1]	Health Care for the Uninsured Paid for by Federal, State, & Local Programs	Total Health Care for the Uninsured Not Paid by the Uninsured or by Government Programs	Total Premiums for Private, Employer-Sponsored Health Insurance	Markup on Private Health Insurance Premiums Due to Health Care for the Uninsured
Alabama	$668,554,000	$422,073,000	$246,481,000	$5,326,499,000	4.6%
Alaska	$124,786,000	$25,796,000	$98,990,000	$728,313,000	13.6%
Arizona	$899,542,000	$148,971,000	$750,571,000	$6,070,297,000	12.4%
Arkansas	$472,039,000	$123,811,000	$348,228,000	$2,747,837,000	12.7%
California	$5,835,900,000	$1,723,481,000	$4,112,418,000	$38,916,581,000	10.6%
Colorado	$713,725,000	$262,091,000	$451,633,000	$5,518,444,000	8.2%
Connecticut	$352,684,000	$118,495,000	$234,189,000	$4,577,709,000	5.1%
Delaware	$91,166,000	$15,382,000	$75,785,000	$1,123,226,000	6.7%
Florida	$2,920,289,000	$943,051,000	$1,977,238,000	$17,658,843,000	11.2%
Georgia	$1,305,077,000	$509,398,000	$795,679,000	$10,915,139,000	7.3%
Hawaii	$148,477,000	$41,251,000	$107,225,000	$1,633,111,000	6.6%
Idaho	$231,633,000	$25,840,000	$205,792,000	$1,550,722,000	13.3%
Illinois	$1,846,383,000	$402,920,000	$1,443,463,000	$16,031,669,000	9.0%
Indiana	$933,838,000	$210,455,000	$723,383,000	$8,056,808,000	9.0%
Iowa	$322,929,000	$132,521,000	$190,408,000	$3,801,896,000	5.0%
Kansas	$299,336,000	$67,822,000	$231,513,000	$3,452,754,000	6.7%
Kentucky	$679,034,000	$217,270,000	$461,764,000	$4,754,225,000	9.7%
Louisiana	$979,079,000	$655,503,000	$323,576,000	$4,583,693,000	7.1%
Maine	$132,913,000	$47,852,000	$85,061,000	$1,472,519,000	5.8%
Maryland	$712,838,000	$118,605,000	$594,232,000	$7,356,374,000	8.1%
Massachusetts	$601,637,000	$310,530,000	$291,107,000	$8,353,549,000	3.5%
Michigan	$1,133,109,000	$269,133,000	$863,975,000	$13,334,033,000	6.5%
Minnesota	$373,290,000	$138,163,000	$235,128,000	$7,176,191,000	3.3%
Mississippi	$498,943,000	$270,035,000	$228,908,000	$3,032,610,000	7.5%
Missouri	$636,097,000	$429,879,000	$206,217,000	$7,138,206,000	2.9%
Montana	$172,437,000	$22,046,000	$150,392,000	$903,990,000	16.6%
Nebraska	$196,926,000	$22,829,000	$174,097,000	$2,142,045,000	8.1%
Nevada	$396,881,000	$83,881,000	$313,001,000	$2,714,261,000	11.5%
New Hampshire	$134,304,000	$21,151,000	$113,153,000	$1,873,675,000	6.0%
New Jersey	$1,171,991,000	$390,415,000	$781,576,000	$11,656,642,000	6.7%
New Mexico	$394,543,000	$83,330,000	$311,213,000	$1,746,656,000	17.8%
New York	$2,732,796,000	$1,455,730,000	$1,277,067,000	$22,161,326,000	5.8%
North Carolina	$1,340,006,000	$367,527,000	$972,479,000	$9,093,987,000	10.7%
North Dakota	$70,229,000	$4,989,000	$65,240,000	$763,496,000	8.5%
Ohio	$1,433,908,000	$253,906,000	$1,180,003,000	$15,258,148,000	7.7%
Oklahoma	$681,481,000	$132,842,000	$548,639,000	$3,562,238,000	15.4%
Oregon	$549,012,000	$124,393,000	$424,618,000	$4,144,234,000	10.2%
Pennsylvania	$1,414,695,000	$408,297,000	$1,006,398,000	$15,507,214,000	6.5%
Rhode Island	$102,813,000	$96,517,000	$6,295,000	$1,361,561,000	0.5%
South Carolina	$606,595,000	$365,257,000	$241,338,000	$4,765,233,000	5.1%
South Dakota	$96,669,000	$13,388,000	$83,280,000	$896,262,000	9.3%
Tennessee	$832,107,000	$332,237,000	$499,871,000	$6,770,488,000	7.4%
Texas	$4,617,127,000	$1,601,940,000	$3,015,187,000	$23,078,344,000	13.1%
Utah	$271,728,000	$35,604,000	$236,123,000	$3,266,725,000	7.2%
Vermont	$53,883,000	$28,397,000	$25,487,000	$740,034,000	3.4%
Virginia	$995,357,000	$279,518,000	$715,839,000	$9,374,560,000	7.6%
Washington	$948,359,000	$222,257,000	$726,102,000	$7,247,248,000	10.0%
West Virginia	$376,497,000	$98,937,000	$277,560,000	$1,837,346,000	15.1%
Wisconsin	$539,259,000	$76,406,000	$462,852,000	$7,134,080,000	6.5%
Wyoming	$75,628,000	$23,217,000	$52,411,000	$552,257,000	9.5%
Total*	**$43,118,528,000**	**$14,175,341,000**	**$28,943,186,000**	**$343,863,298,000**	
Average					**8.5%**

[1] Based on average private insurance rates for services.

* Numbers do not add due to rounding.

Appendix Table 2

2010 Health Care Costs for the Uninsured, by State

State	Total Health Care for the Uninsured Not Paid by the Uninsured [1]	Health Care for the Uninsured Paid for by Federal, State, & Local Programs	Total Health Care for the Uninsured Not Paid by the Uninsured or by Government Programs	Total Premiums for Private, Employer-Sponsored Health Insurance	Markup on Private Health Insurance Premiums Due to Health Care for the Uninsured
Alabama	$935,975,000	$455,307,000	$480,668,000	$7,674,830,000	6.3%
Alaska	$174,701,000	$30,568,000	$144,133,000	$1,049,409,000	13.7%
Arizona	$1,259,359,000	$183,371,000	$1,075,988,000	$8,746,552,000	12.3%
Arkansas	$660,854,000	$154,196,000	$506,659,000	$3,959,296,000	12.8%
California	$8,170,260,000	$2,328,574,000	$5,841,686,000	$56,074,009,000	10.4%
Colorado	$999,215,000	$330,153,000	$669,062,000	$7,951,400,000	8.4%
Connecticut	$493,758,000	$145,886,000	$347,872,000	$6,595,916,000	5.3%
Delaware	$127,633,000	$19,544,000	$108,089,000	$1,618,431,000	6.7%
Florida	$4,088,405,000	$1,092,894,000	$2,995,511,000	$25,444,221,000	11.8%
Georgia	$1,827,108,000	$570,469,000	$1,256,638,000	$15,727,374,000	8.0%
Hawaii	$207,867,000	$97,366,000	$110,502,000	$2,353,113,000	4.7%
Idaho	$324,286,000	$30,503,000	$293,783,000	$2,234,399,000	13.1%
Illinois	$2,584,937,000	$565,881,000	$2,019,056,000	$23,099,663,000	8.7%
Indiana	$1,307,374,000	$239,171,000	$1,068,203,000	$11,608,869,000	9.2%
Iowa	$452,100,000	$142,530,000	$309,570,000	$5,478,065,000	5.7%
Kansas	$419,070,000	$78,169,000	$340,901,000	$4,974,994,000	6.9%
Kentucky	$950,648,000	$256,544,000	$694,104,000	$6,850,254,000	10.1%
Louisiana	$1,370,711,000	$875,496,000	$495,215,000	$6,604,539,000	7.5%
Maine	$186,078,000	$60,704,000	$125,374,000	$2,121,719,000	5.9%
Maryland	$997,973,000	$151,432,000	$846,541,000	$10,599,631,000	8.0%
Massachusetts	$842,292,000	$375,101,000	$467,191,000	$12,036,436,000	3.9%
Michigan	$1,586,352,000	$351,814,000	$1,234,539,000	$19,212,702,000	6.4%
Minnesota	$522,607,000	$166,087,000	$356,519,000	$10,340,008,000	3.4%
Mississippi	$698,520,000	$325,180,000	$373,340,000	$4,369,618,000	8.5%
Missouri	$890,535,000	$481,946,000	$408,589,000	$10,285,277,000	4.0%
Montana	$241,412,000	$28,356,000	$213,057,000	$1,302,538,000	16.4%
Nebraska	$275,697,000	$30,285,000	$245,411,000	$3,086,423,000	8.0%
Nevada	$555,634,000	$100,011,000	$455,623,000	$3,910,917,000	11.7%
New Hampshire	$188,025,000	$26,874,000	$161,151,000	$2,699,735,000	6.0%
New Jersey	$1,640,788,000	$454,903,000	$1,185,885,000	$16,795,789,000	7.1%
New Mexico	$552,360,000	$92,414,000	$459,946,000	$2,516,717,000	18.3%
New York	$3,825,915,000	$1,872,595,000	$1,953,320,000	$31,931,746,000	6.1%
North Carolina	$1,876,008,000	$444,289,000	$1,431,719,000	$13,103,317,000	10.9%
North Dakota	$98,321,000	$6,131,000	$92,190,000	$1,100,104,000	8.4%
Ohio	$2,007,472,000	$293,890,000	$1,713,582,000	$21,985,116,000	7.8%
Oklahoma	$954,074,000	$175,338,000	$778,735,000	$5,132,746,000	15.2%
Oregon	$768,616,000	$150,098,000	$618,518,000	$5,971,332,000	10.4%
Pennsylvania	$1,980,572,000	$511,915,000	$1,468,658,000	$22,343,989,000	6.6%
Rhode Island	$143,938,000	$114,571,000	$29,367,000	$1,961,842,000	1.5%
South Carolina	$849,233,000	$419,939,000	$429,294,000	$6,866,115,000	6.3%
South Dakota	$135,336,000	$16,683,000	$118,653,000	$1,291,403,000	9.2%
Tennessee	$1,164,950,000	$388,610,000	$776,340,000	$9,755,441,000	8.0%
Texas	$6,463,978,000	$1,688,864,000	$4,775,113,000	$33,253,056,000	14.4%
Utah	$380,419,000	$42,439,000	$337,980,000	$4,706,949,000	7.2%
Vermont	$75,437,000	$36,081,000	$39,356,000	$1,066,298,000	3.7%
Virginia	$1,393,500,000	$356,324,000	$1,037,176,000	$13,507,588,000	7.7%
Washington	$1,327,703,000	$256,855,000	$1,070,848,000	$10,442,394,000	10.3%
West Virginia	$527,095,000	$119,988,000	$407,107,000	$2,647,390,000	15.4%
Wisconsin	$754,962,000	$108,809,000	$646,153,000	$10,279,333,000	6.3%
Wyoming	$105,879,000	$26,975,000	$78,904,000	$795,734,000	9.9%
Total*	**$60,365,939,000**	**$17,272,122,000**	**$43,093,816,000**	**$496,352,351,000**	
Average					**8.7%**

[1] Based on average private insurance rates for services.

* Numbers do not add due to rounding.

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